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ABSTRACT

This paper summarizes the National Long-Term Care Channeling Demonstration Program, a project designed to test the feasibility and cost effectiveness of an alternative community-based long-term care service delivery concept for the frail elderly which integrated health and social services. Program management and early federal planning efforts are discussed, and an overview of the purposes of Channeling is provided. Descriptions are given for the two Channeling models used: Basic Case Management (five sites) and Financial Control (five sites). Core functions of Channeling are discussed in the areas of screening, assessment, care planning, arranging for services, follow-up and monitoring, and reassessment. The population, cost consciousness, work with informal supports, and health and social services are identified as factors involved in case management. Four major phases in the Channeling demonstration are discussed: demonstration planning, buildup, steady state, and closeout. The technical assistance contract for the Channeling demonstration is identified, project evaluation is described, major data collection activities are listed, and major findings are reported. Tables are provided which illustrate project milestones, Channeling sites and host agencies, Channeling demonstration eligibility criteria, and elements of the evaluation research design. (NB)

GENERAL SUMMARY
OF THE
NATIONAL LONG-TERM CARE CHANNELING DEMONSTRATION

Revised January 1987

The channeling program was an intradepartmental long-term care initiative funded by the Health Care Financing Administration (HCFA), Administration on Aging (AoA), and the Assistant Secretary for Planning and Evaluation (ASPE). The DHHS project officer is Ms. Mary Harahan, Director, Division of Disability, Aging and Long-Term Care, Office of the Secretary, Department of Health and Human Services, Room 4102, Hubert H. Humphrey Building, Washington, D.C. 20201.

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NATIONAL LONG-TERM CARE CHANNELING DEMONSTRATION PROGRAM

The U.S. Department of Health and Human Services (DHHS), in recognition of the large and rapidly growing need for long-term care for the functionally impaired elderly, funded a major demonstration to test the feasibility and cost-effectiveness of an alternative community-based long-term care service delivery concept integrating health and social services.

Ten community projects in ten different States participated in the National Long-Term Care Channeling Demonstration. Participating States were Florida, Kentucky, Maine, Maryland, Massachusetts, New Jersey, New York, Ohio, Pennsylvania, and Texas.

A. PROGRAM MANAGEMENT

The Channeling demonstration was an intradepartmental long-term care initiative funded by the Health Care Financing Administration (HCFA), the Administration on Aging (AoA), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE). The Assistant Secretary for Planning and Evaluation was responsible for the coordination and implementation of overall program policy in cooperation with the Administrator of the Health Care Financing Administration and the Assistant Secretary for the Office of Human Development Services.

B. EARLY FEDERAL PLANNING EFFORTS

Planning for the Channeling demonstration began at the Federal level in 1978. The initial Federal concept of a service planning and coordination agency (as originally identified in a government briefing memorandum dated July 14, 1978) entailed creating new agencies with three inter-related functions: (1) to channel all or part of the long-term care population -- that is, to match those in need with appropriate long-term care service settings; (2) to plan for the long-term care service system to ensure that sufficient supplies of needed services and settings would be available; and (3) to coordinate directly or indirectly the provision of long-term care services.

In fiscal year 1980, Congress appropriated $20 million for a long-term care initiative to be designed and implemented by three groups within DHHS. Funding for such a research and demonstration effort was included in the research budgets of AOA and HCFA. The responsibility for managing the initiative was lodged in ASPE, reflecting statements in the congressional committee report on the budget and in a letter from the Appropriations Committee as to the intent of Congress.

The Federal planning efforts culminated in the issuance in April of 1980 of a request for proposals from States interested in operating a Channeling project. The States, a technical assistance contractor, and an evaluation contractor were selected in September of 1980.

DHHS had overall responsibility for the demonstration. The technical assistance and evaluation contractors had demonstration-wide responsibilities carried out under DHHS' direction. The fact that these activities were all demonstration-wide was crucial to the establishment of uniform procedures across sites, the commitment of State and site staff to the evaluation objectives of the demonstration, and the faithfulness of program operators to the operational procedures imposed on them by the research requirements.

DHHS announced the selection of 12 States in September of 1980: Florida, Hawaii, Kentucky, Maine, Maryland, Massachusetts, Missouri, New Jersey, New York, Ohio, Pennsylvania, and Texas. (Hawaii and Missouri were later dropped for budgeting reasons from the group of research sites included in the national evaluation of Channeling, although they continued to operate their Channeling programs.)

C. OVERVIEW

Channeling was the provision of community-based long-term care services to people 65 and older who are functionally impaired and are unable to manage the essential activities of daily living (ADL) on their own, and who lack adequate informal supports. The core purposes of the Channeling demonstration were:

- to marshall and direct long-term care resources in a community in ways that contain overall costs;
- to increase access to a wider range of services than is currently available;
- to match services used to the identified needs of the client;
- to concentrate public resources on those persons with the greatest need for subsidized long-term care;
- to stimulate the development of needed in-home and community services which do not exist or are in short supply;
- to reduce the unnecessary use of publicly-subsidized long-term care services, including costly medical and institutional services;
- to promote efficiency and quality in community long-term care delivery systems;
- to promote a reasonable division of labor between informal support systems (including families, neighbors, and friends), privately financed services and publicly-financed care; and
- to maintain or enhance client outcomes, including physical and mental functioning and quality of life.

Two models of Channeling were tested in the demonstration: a Basic Case Management Model and a Financial Control Model (or Complex Model). Although initial plans had called for a second round procurement to select the financial control model projects, Federal resource limitations ruled out this strategy. As a result, it became necessary to select from among the Channeling projects already chosen those that would implement the financial control model.

D. DESCRIPTION OF CHANNELING MODELS

The Basic Case Management Model superimposed a coordinating and accountability mechanism — case management — onto the present system of services and client eligibilities. It accepted the features of the present long-term care system as given and introduced a mechanism responsible for helping clients gain access to and coordinate the services they need to continue to live in the community. The Channeling organization assigned to each client a case manager, who performed a comprehensive assessment of service needs; developed a plan of care that responded to those needs; arranged for the provision of needed services, relying on family and friends where feasible; followed up to see that they are provided and monitored their provision on an ongoing basis; and reassessed needs periodically or when circumstances changed. Thus, the case manager was accountable for identifying the entire package of services needed by the client and served as a client advocate in negotiating the complex array of programs and service providers.

The Basic Case Management Model, therefore, tested the premise that the major difficulties in the current long-term care system are problems of information, access, and coordination, which can be essentially solved by client-centered case management.

The Financial Control Model (or Complex Model) modified the Basic Model to control costs and to strengthen the projects' ability to access needed services. Projects were provided with fixed budgets, set at 60 percent of the average Medicaid Skilled Nursing Facility/Intermediate Care Facility (SNF/ICF) rate in the catchment areas, designed to help gain control over rising costs and increased demand for long-term care services. Federal and State waivers provided reimbursement for a variety of services that offered clients and care planners the opportunity to design more appropriate and efficient care plans than is generally possible under the current fragmented system of categorical programs. Services for which coverage was extended included:

Day Health and Rehabilitative Care
Day Maintenance Care
Home Health Aide Services
Homemaker/Personal Care Services
Housekeeping Services
Chore Services
Companion Service
Home Delivered Meals

Respite Care
Skilled Nursing
Physical Therapy
Speech Therapy
Occupational Therapy
Mental Health Services
Housing Assistance
Adult Foster Care
Nonroutine Consumable Medical Supplies
Adaptive and Assistive Equipment

These services were paid for from a pool of service dollars primarily comprising Medicare and Medicaid funds, made available through waivers of some requirements of those programs. Services reimbursed out of the services pool were not dependent on a client's eligibility for particular categorical programs. Case managers had the power to authorize the amount, duration, and scope of services paid for from the funding pool. This vested in the case manager the power to limit, alter, or terminate services in response to changes in client needs. The power to authorize community-based services, irrespective of funding source, enhanced the case manager's ability to obtain services and control the cost of care plans, making the case manager accountable for the full package of services funded. In addition, clients whose income was above a protected amount (200 percent of SSI, plus State supplement, plus food stamp bonus) were required to share in the cost of services for which they would be subject to an income test outside of Channeling.

E. CORE FUNCTIONS

Both the Basic and the Complex Model included the following core clinical functions.

1. Screen. The process during which information was collected and recorded on the screen instrument, and a preliminary determination made whether an applicant was appropriate for the demonstration by comparing that information to standard selection criteria. The information needed for this comparison included age and nature of the applicant's problems, available formal and informal supports, extent of unmet needs, the probable duration of the needed care, and performance on ADL's (activities of daily living) and IADL's (instrumental activities of daily living).

2. Assessment. The collection of in-depth information about a person's situation and functioning which allows identification of the person's problems in the major functional areas, and permits the development of a plan of care. The Baseline Assessment Instrument was used both for research and clinical purposes.

3. Care Planning. The process of developing an agreement between client and

worker regarding client problems identified, outcomes to be achieved, and services to be provided in support of goal achievement.

4. Arranging for Services. The process of negotiating with service providers, including formal and informal resources, for the delivery of needed services to the client in the manner described in the care plan.

5. Follow-up and Monitoring. The continuing contact the case manager has with providers and clients to ensure that services are being provided in accordance with the care plan and to ascertain whether these services continue to meet the client's needs.

6. Reassessment. The scheduled or event-precipitated re-examination of the client's situation and functioning to identify changes which occurred since the initial or most recent assessment and to measure progress toward the desired outcomes outlined in the care plan.

F. CASE MANAGEMENT

The case manager assessed need, developed a plan of care, coordinated and arranged for services, monitored services provision, reassessed need and revised care plan as the client's condition changed, and served as the client's advocate.

There were several factors involved in Channeling case management:

1. The Population. The clients were frail, vulnerable, severely impaired, often isolated, in need of long-term care services for an extended period of time, and in the absence of Channeling, were at high risk of being institutionalized. More detailed information on the Channeling population is attached in a series of tables.

2. Cost Consciousness. The case managers, usually social workers and nurses, followed procedures that maintained awareness, and allowed control, of the costs of services that comprised plans of care.

3. Work with Informal Supports. The case manager worked with the family, family members, and other informal supports in order to arrange for formal providers to augment what the informal support system was capable of doing.

4. Health and Social Services. The case manager attempted to establish a new set of relationships between health and social service providers to substitute services provided in the community — both formal and informal -- for institutional care, wherever community care is appropriate.

G. PHASES OF THE DEMONSTRATION

There were four major phases in the Channeling demonstration: demonstration planning, buildup, steady state, and demonstration closeout.

1. Demonstration Planning Phase. DHHS signed contracts with the participating States in September of 1980. The planning phase lasted from this date until the local projects became operational. During this phase the sites were selected, detailed administrative and operational procedures designed, staff hired and trained, relationships with local providers and referral sources established, Medicare and Medicaid waivers obtained, financial arrangements for reimbursement of providers completed, data collection instruments designed, and research procedures affecting the local projects defined. The planning phase ended when local projects began accepting clients, which occurred on a staggered basis between February and June of 1982.

2. Buildup Phase. The buildup phase was marked by intense outreach and screening efforts to build project caseloads in order to achieve both the planned research sample size and the planned scale of operations at each site. There were two distinct time periods within this phase. The first, the randomization period, generally started when projects began accepting clients, and was the period during which applicants to Channeling were randomly assigned to the treatment or control group.[1] Randomization ended at a project when it achieved its planned research sample; for all projects this occurred in May-June of 1983. The second, the residual buildup period, started at this point and was the period during which the projects continued to add clients to their caseload totals in order to meet the target caseload sizes established by DHHS for their planned scales of operation. During the residual buildup period, the projects adjusted their staffing patterns to accommodate the requirements of the steady state phase. The buildup phase ended in September of 1983.

3. Steady State Phase. During the steady state phase, which began in October of 1983, the projects were required to maintain a steady caseload size. As clients left the caseload because of death, institutionalization, improvement in condition, and so on, new applicants were screened and accepted to the caseload if eligible. This period most nearly resembled the operation of an ongoing program. There was continual turnover in caseload composition, but caseload and staff sizes were relatively stable. The steady state phase lasted until June of 1984.

4. Demonstration Closeout Phase. During the demonstration closeout phase the projects stopped accepting new clients and implemented their plans

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[1] The four projects which were the first to begin accepting clients (Southern Maine, Baltimore, Houston, and Middlesex County) operated for one to two weeks without randomizing in order to test administrative and clinical procedures.

for the closeout of the federally funded demonstration. The evaluation data do not cover this phase. The nature of the phaseout activities varied greatly from project to project: some went out of operation entirely, but most continued in some fashion with different funding arrangements. This phase extended from July of 1984 to March of 1985, which was the end date of the States' contracts with DHHS. (Fiscal staff in financial control projects were continued to June of 1985 to close out their books for reimbursement of services.)

H. THE TECHNICAL ASSISTANCE CONTRACT

The technical assistance contractor for the Channeling demonstration was Temple University. Major responsibilities included: training screeners, assessors and case managers; responding to the needs of the sites; maintaining the communication network; assisting the government on program issues; and conducting an exploratory study of care planning. A number of program-related materials were developed during the planning and implementation of Channeling. The DHHS contract with Temple University ran from September 30, 1980 through December 1985.

I. THE EVALUATION

Mathematica Policy Research, Inc. (MPR), under contract to DHHS was responsible for evaluating the demonstration. This included the development of the research design, data collection instruments and procedures, the collection of the data and the performance of the analysis. MPR is an independent policy research and evaluation firm based in Plainsboro, New Jersey.

The evaluation employed a randomized experimental design to compare what happens under the demonstration with what would have happened in its absence. Applicants judged appropriate for the demonstration, based on a functional impairment screen, were randomly assigned to either a client or a control group. This permitted a direct comparison of the impact of the demonstration on participants with the outcomes of the control group members who received their services through the conventional delivery system. Participants in the research, both clients and controls, received comprehensive initial and followup interviews designed to gather data about their health, quality of life, use of formal and informal services, and expenditures for services. Additional information on costs and use of formal services were obtained from Medicare/Medicaid records and service provider interviews with informal caregivers. The evaluation also included an analysis of the actual implementation experience of the project, its relation to the existing service delivery system, its costs and its clientele. This analysis was based on interviews with key provider and project staff in the demonstration communities, as well as on data from the instruments used in the impact analysis, project reports, and existing public and project documentation.

All data collection activities involving information about individuals were reviewed and approved by MPR's Institutional Review Board established for protection of human subjects involved in research. All data about individuals remain confidential. Individuals who agreed to participate in the demonstration and research signed an informed consent, as well as releases for access to their records. Data collection forms and instruments were reviewed and approved by the U.S. Office of Management and Budget, and they, along with the project's recordkeeping system, have received clearance under the Federal Privacy Act. The DHHS contract with MPR, Inc. ran from September 30, 1980 through June 15, 1986.

J. MAJOR DATA COLLECTION ACTIVITIES

- Screening data on all appropriate applicants.
- Baseline and two six-month followups on full sample of treatments and controls. 18 month followup on half the sample.
- Medicaid and Medicare claims data on full sample.
- Extracts from provider billing records of services utilized by a 20 percent subsample of treatments and controls.
- Baseline validation interviews by MPR interviewers of about 400 treatment group members.
- Check of death records for sample members who do not have a completed followup interview.
- Baseline and two six-month followup interviews with primary informal caregivers for a subsample of late enrollees.
- Process analysis interviews with staff of States, sites, Temple University, and DHHS.
- Channeling project cost and caseload reports.

K. MAJOR FINDINGS

Major findings from the demonstration include the following:

- The population served by Channeling was extremely frail, had low incomes and reported many unmet needs. The average age was 80 years, the average income was $542 a month and 84 percent were restricted in their ability to perform ADL. The remainder, while having no ADL impairments, had multiple impairments with respect to the IADL. A large majority of respondents (82.5 percent) reported their overall health as fair or poor.

- A high proportion of the Channeling sample was female (70.8 percent). Slightly more than 30 percent were married at the time of their baseline interview. With respect to ethnicity, blacks constituted approximately 24 percent of the sample while Hispanics comprised approximately 4.5 percent. Over one-third of the sample members (37 percent) lived alone and 47 percent had been hospitalized in the two months prior to enrollment in Channeling.

- Channeling's comprehensive case management services were implemented largely according to plan for the treatment group, but a substantial minority of the control group also received case management from other sources.

- Channeling substantially increased the receipt of formal community services; this increase was particularly noteworthy in the Financial Control Model.

- Despite the increase in case management and formal community services, Channeling did not affect hospital use under either model. For example, at the end of the twelfth month after the baseline interview, 3.6 percent of the treatment group and 4.1 percent of the control group in the Basic Model were in a hospital. For the Financial Control Model, 6.2 percent of the treatment group and 5.1 percent of the control group were in a hospital. The treatment-control differences in all cases are not statistically significant.

- Channeling did not affect nursing home use under either model. At the end of the twelfth month after baseline, 11.5 percent of the treatment group and 12.6 percent of the control group in the Basic Model were in a nursing home. For the Financial Control Model, 11.3 percent of the treatment group and 13.5 percent of the control group were in a nursing home. There differences are not statistically significant.

- Channeling did not have a significant effect on the longevity of the sample members under either model. The mortality rate for the sample was about 17 percent six months after random assignment, 27 percent after 12 months and 36 percent after 18 months. There were no statistically significant differences observed between treatment group and control group members.

- There is no evidence that Channeling led to substitution of formal for informal care in the Basic Case Management Model. There was evidence of some substitution in the Financial Control Model. However, it resulted from reductions in caregiving by some friends and neighbors rather than primary caregivers such as spouses or daughters.

- Channeling led to an increase in the total subsistence, medical and long-term care costs per client over the 18 month observation period. The Basic Case Management Model appeared to increase these costs by about $1500 per client or approximately 8 percent above the $18,000 in costs that would be expected without Channeling. In the Financial Control

Model, the cost increase was $3500 or 16 percent over the $23,000 that would otherwise be expected.

- Public expenditures for subsistence, medical treatment and long-term care services for the first 18 months after enrollment increased under both models. In the Basic Model, government costs rose by 10 percent (approximately $1900 per client) and in the Financial Control Model by 17 percent ($3900) per client. These increases were due mostly to the costs of Channeling case management and for the extra formal community services arranged by Channeling.

- Channeling improved the well-being of caregivers by some measures, especially in terms of satisfaction with care arrangements and overall life satisfaction.

- Channeling reduced reported unmet needs, increased confidence in receiving needed services and increased satisfaction with service arrangements for clients. There were small but generally beneficial effects on social and psychological well-being.

TABLE I

MILESTONES IN THE PLANNING AND IMPLEMENTATION OF THE CHANNELING PROJECTS

DATE	EVENT
December 1979	Department of Health & Human Services (DHHS) published notice of intent in the Federal Register to develop a coordinated long-term care Channeling demonstration.
April 1980	DHHS issued request for proposals for Channeling States.
May 1980	DHHS issued requests for proposals for the national technical assistance contractor & the national evaluation contractor.
Planning Phase (September 1980 - Spring 1982)	
September 1980	DHHS selected 12 Channeling demonstration States & the national technical assistance & evaluation contractors. Start of the planning phase.
November 1980	Demonstration States submitted site proposals.
January 1981	DHHS selected 12 Channeling project sites.
June 1981	DHHS issued guidelines for Channeling States wishing to implement the Financial Control Model.
August 1981	DHHS reduced from 12 to 10 the number of national research States and sites.
September 1981	DHHS designated 5 Financial Control Models, the other 5 as Basic Case Management Models.
December 1981	Channeling projects submitted detailed operational plans to DHHS.
Buildup Phase (Spring 1982 - September 1983)	
February 1982	First of the Base Case Management Models began operations after hiring staff; going through screening, assessment & case management training; negotiating referral agreements with priority referral sources; & implementing internal management information & recordkeeping systems.
May 1982	First of the Financial Control Models began operations for completing same tasks as Basic Case Management Models, as well as negotiating provider contracts, implementing the financial control system, & completing funds pool arrangements.

TABLE I (continued)

MILESTONES IN THE PLANNING AND IMPLEMENTATION OF THE CHANNELING PROJECTS

DATE	EVENT
June 1982	All projects were operational.
May 1983	First project reached research sample target.
June 1983	All projects achieved adjusted research sample target. Randomization ended.
July - September 1983	Sites continued to increase their caseloads in order to achieve their target sizes.
Steady State Phase (October 1983 - June 1984)	
	Projects maintained their caseloads at the levels agreed to with DHHS.
Demonstration Closeout Phase (July 1984 - June 1986)	
July 1984 - March 1985	Projects carried out their plans to end Federally supported operations. Some transferred clients to other care arrangements while others prepared to continue under different auspices. Fiscal support staff in Financial Control Models continued until June 1985 to process final provider billings.
December 1985	End of DHHS contract with Temple University.
June 1986	End of DHHS contract with MPR and formal end of the Channeling demonstration.

TABLE II

CHANNELING SITES AND HOST AGENCIES

SITE	HOST AGENCY
Basic Case Management Model	
Eastern Kentucky[1]	State Department of Social Services, Department of Human Resources
York & Cumberland Counties (including Portland), Maine	Southern Maine Senior Citizens, Inc.
Baltimore, Maryland	City of Baltimore, Council on Aging & Retirement Education[2]
Middlesex County (including New Brunswick), New Jersey	County Department of Human Services
Houston, Texas[3]	Texas Research Institute for Mental Sciences
Financial Control Model	
Miami, Florida[4]	Miami Jewish Home & Hospital for the Aged
Greater Lynn, Massachusetts	Greater Lynn Senior Services, Inc.
Rensselaer County (including Troy), New York	Rensselaer County Department on Aging
Cuyahoga County (including Cleveland), Ohio	Western Reserve Area Agency on Aging
Philadelphia, Pennsylvania	Philadelphia Corporation on Aging

[1]The Eastern Kentucky site included Clay, Harlan, Jackson, Knott, Laurel, Leslie, Letcher, and Perry counties.

[2]The Council on Aging & Retirement Education is the Area Agency on Aging in Baltimore.

[3]The Houston site included most but not all of Houston.

[4]The Miami site included Miami Beach, but not all of Miami.

TABLE III

CHANNELING DEMONSTRATION ELIGIBILITY CRITERIA

	CRITERION
Age	Must be 65 or over.
Residence	Must reside within project catchment area; must be living in community or (if institutionalized) certified as likely to be discharged within three months.
Functional Disability	Must have at least two moderate ADL disabilities, or three severe IADL impairments, or two IADL impairments and one severe ADL disability.[1] (Cognitive or behavioral difficulties affecting individual ability to perform ADL can count as one of the severe IADL impairments.)
Unmet Needs or Fragile Informal Support	Must need help with at least two categories of service affected by functional impairments for six months (meals, housework/shopping, medications, medical treatments at home, personal care), or have a fragile informal support system that may no longer be able to provide needed care.
Insurance Coverage	Must be Medicare Part A eligible (for the Financial Control Model).

[1]The six ADL activities include bathing, dressing, toileting, transfer, continence, and eating. The seven IADL activities are housekeeping, shopping, meal preparation, taking medicine, travel, using the telephone, and managing finances. For the purpose of the IADL eligibility criterion, the first two and the last three IADLs were aggregated into two combined categories. Thus there are four possible IADL areas under which applicants can qualify, plus the congnitive/behavioral impairment category which counts as one IADL item.

TABLE IV

EVALUATION OF THE NATIONAL LONG-TERM CARE CHANNELING DEMONSTRATION
PRINCIPAL ELEMENTS OF THE RESEARCH DESIGN

RESEARCH COMPONENT	RESEARCH QUESTIONS	PRIMARY DATA SOURCES
Service Use	Did Channeling reduce institutionalization & hospitalization for clients? Did it increase clients' utilization of formal health & social services provided in the community? Do informal services increase or decrease? Do formal services substitute for informal ones?	Individual Interviews; Provider Records (20% sample); Medicare/Medicaid Records; Informal Caregiver Interviews
Costs	Did Channeling increase or decrease the public & private costs of long-term care with respect to nursing homes & hospitals, formal community-based services, housing & living expenses, & case transfers?	Individual Interviews; Provider Records (20% sample); Medicare/Medicaid Records
Individual Outcomes	Did Channeling result in greater longevity, reduced functional deterioration, improved social & psychological well-being, lower unmet need, & increased service satisfaction?	Individual Interview; Death Records
Informal Caregiver Outcomes	How did Channeling affect caregivers' stress & well-being, satisfaction with care, employment & income, & financial support provided to Channeling clients?	Individual Interview; Informal Caregiver Interviews
Implementation & Process	How were the projects implemented? What were the characteristics of Channeling clients? What were the costs of Channeling? What approaches would be most effective for implementing future programs like Channeling?	Process Interviews; Research Instruments (screen & others above); Project Cost & Client Tracking Reports; Public & Project Documents
Cost Versus Benefits	Were the costs of Channeling out-weighed by its benefits? Was one model relatively more cost-effective than the other?	(Based on findings of other research components)